De-medicalising contraception

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Scope of presentation
Supporting women’s autonomy

- Unmet need
- Drivers and access
- OTC OC
- The South London Pilot
- Other non-medical delivery models
The unmet need

- 25% in low resource countries, [up to 300 000 000]
- In Africa alone, in 2012 unmet need resulted in 79 000 maternal deaths Darroch et al, Contraception 2012
- Access an issue in developed societies due to hierarchies
- Young people and the socially underprivileged more vulnerable
- Globally, system failures: a combination of shortage of HCPs and supplies limit access
Increased access = fewer maternal deaths


Terms and Conditions
Global OC prescription requirements

- Informally available without Rx
- Formally available without Rx (no screening required)
- Formally available without Rx (screening required)
- Only available with Rx
- Only available with Rx (screening required)
- Data not available

www.OCsOTC.org
Selling birth control pills over the counter would reassure millions of women who don't take them because of misinformation about risks and side effects. The category of nonsteroidal anti-inflammatory drugs, to which aspirin and ibuprofen belong, is associated with 16,000 deaths a year, while the pill actually causes users to live slightly longer than average. The wider availability of the pill would help those who lack insurance or can't afford to go to a doctor. Today, poor women have three times as many unintended pregnancies as wealthier women.

Malcolm Potts 2012 LA Post
Advocacy: the league table

- International [FIGO, FIAPAC, ESC, FSRH]
- Regional [IBIS]
- Consortia [ICEC, ECEC]
- Country specific [fpa, OCsOTC]
What’s good about a prescription?

- Generates money to the Healthcare system/private physician
- Allows consultation, screening and full choice
- Safer

- But substantial savings likely with OTC
- BUT WHO SPRs do not require an Examination & choice is achievable through targeted information & BCAS SHOWS 91% PAP coverage vs 85% national coverage
- But the user is best placed to recognise risk factors and can self select
Can women self select?

- Most can

- For some; facilitated self management is appropriate and provided by a trained pharmacist

- A few need in-depth counselling

- No difference in identifying contraindications in OTTC vs clinic based services
  
  White K. et al, Contraception 2012
Pill Kiosks
A team at the University of Pittsburgh created a computer kiosk to help women determine if they should take birth-control pills or whether they smoked, had migraines with an aura or other conditions that may make taking the pills inadvisable.
Challenge myths: Can you misuse an OC?

- You can give it to your plant
- You cannot get high on OCs
- You can’t overdose
- You can put it in the vagina – works better?
- It does not make you infertile
Would it encourage irresponsible behaviour?

Evidence from EHC says not likely

Glasier A. Contraception 2012
Two studies from the Border Contraceptive Access Study

BCAS researchers have published two papers from the Border Contraceptive Access Study in the March 2011 issue of *Obstetrics & Gynecology*. The first paper shows that women who obtain oral contraceptives over the counter in Mexico are likely to stay on the birth control pill longer than those who obtain pills by prescription at U.S. clinics. In the second paper, the researchers found that women who obtained combined oral contraceptives, in Mexico were significantly more likely than U.S. clinic users to have health conditions such as hypertension.
Would pharmacists cope?

- They do this all the time
- They are better placed to check interactions and contraindications
- But need the right environment
  - Privacy
  - Professionalism
- Formulary?
What the women say about privacy; the South London experience

- It is a quick way to get contraception, it is very private unlike a clinic where everyone knows what you are there for
Would advisors to regulatory bodies give the green light?

- Initiation vs. continuation
  - [? Repeat pills only]
- POP to go OTC 1st
- Agree if within a network
- Quality assured training
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<th>Page</th>
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The South London experience

- Started in October 2009
- Standardised training to pharmacists with attachment to clinics
- PGD based service
- Initiation and refills
- Already provide EHC, Chlamydia testing and treatment, free condoms
- Established a London Pharmacy Contraceptive Group
October 09-June 2011
741 consultations in 4 pharmacies

<table>
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<th>outcome</th>
<th>%</th>
<th>notes</th>
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<tr>
<td>Initiating OC in established user/1\textsuperscript{st} user Continuation OC</td>
<td>69</td>
<td>25% had never used OC</td>
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<tr>
<td></td>
<td>24.4</td>
<td></td>
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<tr>
<td>General referral to other service</td>
<td>4.9</td>
<td>Had other needs</td>
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<tr>
<td>LARC referral</td>
<td>1.2</td>
<td>Eventually will provide on site</td>
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<td>&lt; 16 referral</td>
<td>0.4</td>
<td>1/4 &lt;19</td>
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Demographics - age

- 95% aged 30 and under
- 70% 24 and under
- 25% 19 and under

Percentage of consultations per age group (Oct 09 - Apr 10)

- Under 16 years: 0%
- 16-19 years: 24%
- 20-24 years: 45%
- 25-30 years: 26%
- 31-40 years: 3%
- Over 40 years: 2%
Demographics - ethnicity

- Black African/ British/ Caribbean/ other – 59%
- White British/ Irish/ other – 20%
- Mixed white & black African or Caribbean/ mixed other – 4%
- Asian British/ Indian/ Bangladeshi /other – 3%
- Other ethnic group – 3%
- No data – 10%

Percentage of females aged 15-24 per ethnic group (Lambeth and Southwark average)

- Black African – 15%
- Black British – 9%
- Black Caribbean – 6%
- White British – 12%

Percentage of consultations per ethnic group (Oct 09 - Apr 10)

- Black African – 24%
- Black British – 20%
- Black Caribbean – 14%
- White British – 11%
- Other ethnic group – 10%
- Mixed White and Black Caribbean – 8%
- Asian British – 3%
- Black other – 3%
- Indian – 3%
- Chinese – 3%
- Other ethnic group – 10%
- Mixed White and Black African – 11%
- Asian other – 10%
- Mixed other – 10%
- White Irish – 10%
- No data – 10%
Impact on EC pharmacy work

Month

Number of consultations

Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11

220
200
180
160
140
120
100

202
165
146
157
162
146
136
137
142
146
138
105
103
109
123
Non-medical delivery models

- Task sharing to nurses/auxiliary nurses/community health workers/client support workers/pharmacists
- OTC + working with a care pathway to refer for LARC or other care
- OTC without pathway
- Web based support

Optimizing the health workforce
WHO 2012
Tasks that can be delivered effectively at lower cost: by client support workers

- Venepuncture
- Advising patients how to self swab/sample
- Pregnancy testing and advice
- Asymptomatic STI screens
- Uncomplicated contraception
- Vaccination
- Maintenance of clinical environment/manage vending machines
Task sharing: nurse delivered, consultant led service for IUCs, implants, prescribing

- A safe practice
- Same training standards and competency thresholds
- Strong nursing leadership
- Nurse prescribers support
- Redefinition of roles
  - Specialists for complex work
  - Sharing outreach work and care of vulnerable groups
- Primary care role
Shortage of doctors in LDCs means most FP interventions delivered by non-medics

- static clinics
- mobile clinics
- rural outreach teams
- community volunteers
- social marketing
- social franchising - BlueStar
- work-based initiatives
- peer education programmes
- community based-activities
- refugee / IDP camps
Social marketing

- Utilises existing expertise and commercial resources.
- Makes contraceptives readily available at affordable prices in the community.
- Mobilises customer-driven, not provider determined systems.
- Bypasses inefficient, bureaucratic Government channels.
- Introduces an element of cost recovery.
- Is highly efficient and cost-effective.
MHealth/EHealth[health on the move]: The simple text message represent a quantum leap in LDCs

- **Text for:**
  - Appointment
  - Information
  - To ask if supplies OK [UNICEF mTrac]
  - To feedback on a service
  - To monitor health care activities [e.g. is free HIV testing available?]

- **Web and social media:**
  - virtual clinics
  - Information
  - Community mobilisation
  - alerts
Conclusion

Many advantages to de-medicalising contraception and SH interventions

- Empowers users to take control of their health through:
  - Information/myth busters
  - Self selection using MEC
  - Harnessing potential of mobile/web & social media

- For the provider - greater effectiveness
  - through increasing access, to meet rising demand
  - Cost effectiveness through task shifting and networks
  - Outreach, high street, & virtual provision gets to difficult to get to groups

- But to make it happen, we must:
  - Adopt EB Practice/regulations
  - Strengthen multidisciplinary pathways/protocols
  - Advocate a rights and choice agenda

Every child a wanted child
Thank you

“\textbf{I regard golf as an expensive way of playing marbles.}”
See you in Copenhagen